ADULT FULL ASSESSMENT

Date of first assessment contact: _____

Assessing Practitioner (Name and Discipline): _____

Client/Others Interviewed: _____

I. Demographic Data & Special Service Needs:

DOB: _____ Gender: _____ Ethnicity: _____ Marital Status: _____

Referral Source:

☐ Non-English Speaking, specify language used for this interview: _____

Were Interpretive Services provided for this interview? ☐ Yes ☐ No

☐ Cultural Considerations, specify: _____

☐ Physically challenged (wheelchair, hearing, visual, etc.) specify: _____

☐ Access issues (transportation, hours), specify: _____

II. Reason for Referral/Chief Complaint

Describe precipitating event(s)/Reason for Referral,

Current Symptoms and Behaviors (intensity, duration, onset, frequency) and Impairments in Life Functioning caused by the symptoms/behaviors (from perspective of client and others):

Client Strengths (to assist in achieving treatment goals)

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III. Mental Health History:

History of Problem Prior to Precipitating Event: Include treated & non-treated history.

Impact of treatment and non-treatment history: on the client's level of functioning, e.g., ability to maintain residence, daily living and social activities, health care, and/or employment.

Psychiatric Hospitalizations: ☐ Yes ☐ No ☐ Unable to Assess
If yes, describe dates, locations, and reasons

Outpatient Treatment: ☐ Yes ☐ No ☐ Unable to Assess
If yes, describe dates, locations and reasons.

Suicidal/Homicidal Thoughts/Attempts
Columbia Suicide Risk Severity Scale Completed? ☐ Yes ☐ No (For Directly-Operated)
If Columbia Suicide Risk Severity Scale NOT completed, describe below and include dates, threat, intent, plan, target(s), access to lethal means, method used:

Self-Harm (without statement of suicidal intent) ☐ Yes ☐ No ☐ Unable to Assess
If yes, describe

Trauma or Exposure to Trauma: ☐ Yes ☐ No ☐ Unable to Assess
Has client ever (1) been physically hurt or threatened by another, (2) been raped or had sex against their will, (3) lived through a disaster, (4) been a combat veteran or experienced an act of terrorism, (5) been in a severe accident, or been close to death from any cause, (6) witnessed death or violence or the threat of violence to someone else, or (7) been the victim of a crime?

IV. Medications

List "all" past and present psychotropic medications used, prescribed/non-prescribed,by name, dosage, frequency. Indicate from client's perspective what seems to be working and not working.

Medication	Dosage/Frequency	Period Taken	Effectiveness/Response/Side Effects/Reactions

General Medication Comments (include significant non-psychotic medication issues/history):

V. Substance Use/Abuse

"MH659 -Co-Occurring Joint Action Council Screening Instrument"

1. Were any of the questions checked "Yes" in Section 2 "Alcohol & Drug Use"? ☐ Yes* ☐ No **If yes, complete MH633**
2. Were any of the questions checked "Yes" in Section 3 "Trauma/Domestic Violence"? ☐ Yes ☐ No **If yes, answer 2a**

2a. Was the Trauma or Domestic Violence related to substance use? ☐ Yes* ☐ No **If yes, complete MH633**

Be sure to document re: Trauma or Domestic Violence in Part A of "Psychosocial History" on page 3 of the Initial Assessment.

Does the client currently appear to be under the influence of alcohol or drugs? ☐ Yes ☐ No ☐ Unable to Assess
If yes, When was the last time the client used alcohol or drugs?

Has the client ever received professional help for his/her use of alcohol or drugs? ☐ Yes ☐ No ☐ Unable to Assess
Comments on alcohol/drug use:

How is Mental Health impacted by substance use (Clinician's Perspective)? Must be completed if any services will be directed towards Substance Use/Abuse.

* MH 633 "Supplemental Co-Occurring Disorders Assessment" completed on: _____

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VI. Medical History

MD Name: _____ **MD Phone:** _____ **Date of Last Physical Exam:** _____

Major medical problem (treated or untreated) (Indicate problems with check: Y or N for client, Fam for family history.)

Fam	Y	N		Fam	Y	N		Fam	Y	N		Fam	Y	N	
☐	☐	☐	Seizure/neuro disorder				Cardiovascular disease/symp				Liver disease				Diarrhea
	☐	☐	Head trauma				Thyroid disease/symp				Renal disease/symp	☐			Cancer
	☐	☐	Sleep disorder				Asthma/lung disease				Hypertension		☐	☐	Sexual dysfunction
	☐	☐	Weight/appetite chg				Blood disorder	☐	☐		Diabetes				Sexually trans disease
☐	☐	☐	Allergies (If Yes, specify):												
	☐	☐	Sensory/Motor Impairment (If Yes, specify):												
	☐	☐	Pap smear If yes, date: _____				Mammogram If yes, date: _____				HIV Test If yes, date: _____		☐	☐	Pregnant If yes, due date: _____

Comments on above medical problems, other medical problems, and any hospitalizations, including dates and reasons.

VII. Psychosocial History

Please state specifically how Mental Health status directly impacts each area below; Be sure to include the client's strengths in each area.

Education

Special Education: ☐ Yes ☐ No ☐ Unable to Assess Learning Disability: ☐ Yes ☐ No ☐ Unable to Assess

Motivation, education goals, literacy skill level, general knowledge skill level, math skill level, school problems, etc:

Employment History, Readiness for Employment and Means of Financial Support

Current Paid Employment: ☐ Yes ☐ No ☐ Unable to Assess Military Service: ☐ Yes ☐ No ☐ Unable to Assess

Work related problems, volunteer work, money management, source of income, longest period of employment, etc:

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Legal History and Current Legal Status

Arrests/DUI, probation, convictions, divorce, conservatorship, parole, child custody, etc:

Current Living Arrangement and Social Support Systems

Type of living setting, problems at setting, community, religious, government agency, or other types of support, etc:

Dependent Care Issues

Number of Dependent Adults: _____ Number of Dependent Children: _____

Ages of children, school attendance/behavior problems of children, special needs of dependents, foster care/group home placement issues, child support, etc:

Family and Relationships

History of Mental Illness in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess

Alcohol/Drug Abuse in Immediate Family: ☐ Yes ☐ No ☐ Unable to Assess

Family constellation, family of origin, family dynamics, cultural factors, nature of relationships, domestic violence, physical or sexual abuse, home safety issues, family medical history, family legal/criminal issues

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VIII. Mental Status Evaluation

Instructions: Check all descriptions that apply

General Description

Grooming & Hygiene: ☐ Well Groomed
☐ Average ☐ Dirty ☐ Odorous ☐Disheveled
☐ Bizarre
Comments:

Eye Contact: ☐ Normal for culture
☐ Little ☐ Avoids ☐ Erratic
Comments:

Motor Activity: ☐ Calm ☐ Restless
☐ Agitated ☐ Tremors/Tics ☐ Posturing ☐ Rigid
☐ Retarded ☐ Akathesis ☐ E.P.S.
Comments:

Speech: ☐ Unimpaired ☐ Soft
☐ Slowed ☐ Mute ☐ Pressured ☐ Loud
☐ Excessive ☐ Slurred ☐ Incoherent
☐ Poverty of Content
Comments:

Interactional Style: ☐ Culturally congruent
☐Cooperative ☐ Sensitive
☐ Guarded/Suspicious ☐ Overly Dramatic
☐ Negative ☐ Silly
Comments:

Orientation: ☐ Oriented
☐ Disoriented to:
☐ Time ☐ Place ☐ Person ☐ Situation
Comments:

Intellectual Functioning: ☐ Unimpaired
☐ Impaired
Comments:

Memory: ☐ Unimpaired
☐ Impaired re: ☐ Immediate ☐ Remote ☐ Recent
☐ Amnesia
Comments:

Fund of Knowledge: ☐ Average
☐ Below Average ☐ Above Average
Comments:

Mood and Affect

Mood: ☐ Euthymic ☐ Dysphoric ☐ Tearful
☐ Irritable ☐Lack of Pleasure
☐ Hopeless/Worthless ☐ Anxious
☐ Known Stressor ☐ Unknown Stressor
Comments:

Affect: ☐ Appropriate ☐ Labile ☐ Expansive
☐ Constricted ☐ Blunted ☐ Flat ☐ Sad
☐ Worried
Comments:

Perceptual Disturbance

☐ None Apparent

Hallucinations: ☐ Visual ☐ Olfactory
☐ Tactile ☐ Auditory: ☐ Command
☐ Persecutory ☐ Other
Comments:

Self-Perceptions: ☐ Depersonalizations
☐ Ideas of Reference
Comments:

Thought Process Disturbances

☐ None Apparent

Associations: ☐ Unimpaired ☐ Loose
☐ Tangential ☐ Circumstantial ☐ Confabulous
☐ Flight of Ideas ☐ Word Salad
Comments:

Concentration: ☐ Intact ☐ Impaired by:
☐ Rumination ☐ Thought Blocking
☐ Clouding of Consciousness ☐ Fragmented
Comments:

Abstractions: ☐ Intact ☐ Concrete
Comments:

Judgments: ☐ Intact
☐ Impaired re: ☐ Minimum ☐ Moderate ☐ Severe
Comments:

Insight: ☐ Adequate
☐ Impaired re: ☐ Minimum ☐ Moderate ☐ Severe
Comments:

Serial 7's: ☐ Intact ☐ Poor
Comments:

Thought Content Disturbance

☐ None Apparent

Delusions: ☐ Persecutory ☐ Paranoid ☐ Grandiose
☐ Somatic ☐ Religious ☐ Nihilistic
☐ Being Controlled
Comments:

Ideations: ☐ Bizarre ☐ Phobic ☐ Suspicious
☐ Obsessive ☐ Blames Others ☐ Persecutory
☐ Assaultive Ideas ☐ Magical Thinking
☐ Irrational/Excessive Worry
☐ Sexual Preoccupation
☐ Excessive/Inappropriate Religiosity
☐ Excessive/Inappropriate Guilt
Comments:

Behavioral Disturbance

Behavioral Disturbances: ☐ None ☐ Aggressive
☐ Uncooperative ☐ Demanding ☐ Demeaning
☐ Belligerent ☐ Violent ☐ Destructive
☐ Self-Destructive ☐ Poor Impulse Control
☐ Excessive/Inappropriate Display of Anger
☐ Manipulative ☐ Antisocial
Comments:

Suicidality/Homicidality

Suicidal: ☐ Denies ☐ Ideation Only
☐ Threatening ☐ Plan
Comments:

Homicidal: ☐ Denies ☐ Ideation Only
☐ Threatening ☐ Target ☐ Plan
Comments:

Other

Passive: ☐ Amotivational ☐ Apathetic
☐ Isolated ☐ Withdrawn ☐ Evasive ☐ Dependent
Comments:

Other: ☐ Disorganized ☐ Bizarre
☐ Obsessive/compulsive ☐ Ritualistic
☐ Excessive/Inappropriate Crying
Comments:

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IX. Summary and Diagnosis

I. Diagnostic Summary: (Be sure to include assessment for risk of suicidal/homicidal behaviors, significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e., Work, School, Home, Community, Living Arrangements, etc, and justification for diagnosis)

II. Diagnostic Descriptor

_____
_____
_____
_____
_____
_____
_____
_____
_____

ICD Diagnosis Code (check at least one Primary)

Primary Code _____
Sec Code _____
Code _____
Code _____
Code _____
Code _____
Code _____
Code _____
Code _____

III. Specialty Mental Health Services Medical Necessity Criteria:

1. Medi-Cal Specialty Mental Health Included Diagnosis — Yes / No
2. Significant impairment in life functioning due to the Included Diagnosis — Yes / No
3. Expectation that proposed interventions can impact the client's condition — Yes / No
4. Mental Health Condition will not be responsive to physical health care based treatment — Yes / No

IV. Disposition/Recommendations/Plan

V. Signatures

_____	_____	_____	_____
Assessor's Signature & Discipline	Date	Co-Signature & Discipline	Date

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